Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Medial Branch Block Right L5/S1 Lumbar Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Spine Surgeon, Practicing Neurosurgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
12/03/08 – CT ABDOMEN AND PELVIS
05/06/09 – OPERATIVE REPORT
06/05/09 – CLINICAL NOTE –MD
07/08/09 – MRI LUMBAR SPINE
07/31/09 – CLINICAL NOTE –MD
01/20/10 – CLINICAL NOTE –MD
01/20/10 – RADIOGRAPHS LUMBAR SPINE
02/03/10 – UTILIZATION REVIEW DETERMINATION
02/12/10 – DESIGNATED DOCTOR EVALUATION –MD
02/17/10 – CLINICAL NOTE –MD
02/17/10 – BHI2 ENHANCED INTERPRETIVE REPORT
03/02/10 – ELECTRODIAGNOSTIC STUDIES
03/04/10 – CLINICAL NOTE –MD
03/04/10 – MANUAL MUSCLE TEST
04/12/10 – CLINICAL NOTE –MD
04/12/10 – MANUAL MUSCLE TEST
04/12/10 – CORRESPONDENCE –MD
04/21/10 – OPERATIVE REPORT
04/21/10 – SURGICAL PATHOLOGY REPORT
04/27/10 – CLINICAL NOTE –MD
05/21/10 – CLINICAL NOTE –MD
05/21/10 – MANUAL MUSCLE TEST
05/21/10 – RADIOGRPAHS LUMBAR SPINE

06/17/10 – DESIGNATED DOCTOR EVALUATION –MD
07/01/10 – CLINICAL NOTE –MD
07/01/10 – MANUAL MUSCLE TEST
08/05/10 – CLINICAL NOTE –MD
08/31/10 – RADIOGRAPHS CHEST
08/31/10 – LUMBAR MYELOGRAM
08/31/10 – CT LUMBAR SPINE
09/16/10 – CLINICAL NOTE –MD
09/27/10 – UTILIZATION REVIEW DETERMINATION
10/06/10 – UTILIZATION REVIEW DETERMINATION
10/28/10 – OPERATIVE REPORT
11/05/10 – CLINICAL NOTE –MD
11/05/10 – MANUAL MUSCLE TEST
12/17/10 – CLINICAL NOTE –MD
12/17/10 – MANUAL MUSCLE TEST
12/28/10 – UTILIZATION REVIEW DETERMINATION
01/21/11 – OPERATIVE REPORT
01/31/11 – CLINICAL NOTE –MD
01/31/11 – MANUAL MUSCLE TEST
03/10/11 – CLINICAL NOTE –MD
03/22/11 – CLINICAL NOTE –MD
03/22/11 – MANUAL MUSCLE TEST
05/04/11 – UTILIZATION REVIEW DETERMINATION
05/16/11 – UTILIZATION REVIEW DETERMINATION
05/16/11 – REQUEST FOR REVIEW BY INDEPENDENT REVIEW ORGANIZATION
06/03/11 – UTILIZATION REVIEW DETERMINATION
06/03/11 – CORRESPONDENCE –MD
07/11/11 – CLINICAL NOTE –MD
07/25/11 – CLINICAL NOTE –MD
10/14/11 – CLINICAL NOTE –MD
10/14/11 – MANUAL MUSCLE TEST
12/09/11 – CLINICAL NOTE –MD
02/06/12 – CLINICAL NOTE –MD
02/06/12 – MANUAL MUSCLE TEST
05/02/12 – CLINICAL NOTE –MD
05/11/12 – UTILIZATION REVIEW DETERMINATION
05/22/12 – CLINICAL NOTE –MD
06/04/12 – UTILIZATION REVIEW DETERMINATION
06/11/12 – CLINICAL NOTE –MD
06/19/12 – REQUEST FOR REVIEW BY INDEPENDENT REVIEW ORGANIZATION
06/19/12 – CORRESPONDENCE –
06/20/12 – NOTICE TO INDEPENDENT RESOLUTIONS, INC OF CASE ASSIGNMENT

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who sustained an injury to the lumbar spine on xx/xx/xx. The claimant underwent bilateral L5-S1 discectomy and bilateral hemilaminectomy with medial facetectomy and bilateral foraminotomy on 05/06/09. MRI of the lumbar spine performed 07/08/09 revealed surgical changes from L5-S1 laminotomy. There was epidural fibrosis of the right L5-S1 canal and surrounding the traversing right S1 nerve root sheaths. There was enhancing granulation tissue in the right paracentral disc protrusion, compatible with post-surgical change. Extensive epidural fat significantly narrowed the thecal sac from L4-5 to its termination in the mid sacrum. Electrodiagnostic studies performed 03/02/10 revealed findings suggestive of right S1-2 radiculopathy with evidence of denervation. The claimant underwent revision L5-S1 lumbar laminectomy and microdiscectomy with insertion of interbody annular mesh repair on 04/21/10.

Lumbar myelogram performed 08/31/10 revealed considerable attenuation of the thecal sac at L5-S1 with associated increased anterior epidural space at L5-S1. There was slight to moderate narrowing of the lateral recess bilaterally due to short pedicles at L4-5. Post-

myelogram CT of the lumbar spine performed 08/31/10 revealed slight to moderate narrowing of the lateral recess bilaterally at L4-5 due to short pedicles. There was borderline narrowing of the central canal with some hypertrophy of the ligamentum flavum. At L5-S1, there was marked attenuation of the thecal sac with increased epidural space anteriorly due to fatty tissue, most likely based on epidural lipomatosis at L5-S1. The claimant underwent L5-S1 epidural steroid injection on 10/28/10 and 01/21/11. The claimant reported 70% relief from both injections. The claimant saw Dr. on 02/06/12 with complaints of low back pain with radiation down the right lower extremity and associated numbness and tingling. Physical exam revealed tenderness to palpation of the lower lumbar region. Lumbar range of motion was decreased. Straight leg raise was reported to be positive on the right. There was mild paresthesia along the right S1 distribution. The right Achilles reflex was absent. The claimant's medications were refilled.

The claimant saw Dr. on 05/02/12 with complaints of increased low back pain rating 5 out of 10. The claimant also reported occasional right lower extremity symptoms. Physical exam revealed tenderness to palpation of the right L5 and S1 paravertebral area. Kemp's was positive. Lumbar range of motion was decreased. Straight leg raise elicited back pain. The right Achilles reflex was absent. The claimant was assessed with right L5-S1 facet pain syndrome. The claimant was recommended for right L5 and S1 diagnostic medial branch block. The request for outpatient medial branch block right L5-S1 lumbar spine was denied by utilization review on 05/11/12 due to no clearly defined objective signs or symptoms of facet related pains. There was no reliable referral pattern. There was evidence of clearly defined radicular pain. The claimant saw Dr. on 05/22/12. Physical exam revealed severe tenderness to palpation at the right L5 and S1 levels. Straight leg raise elicited back pain. The claimant was thought to have permanent nerve root irritation to the right lower extremity due to the lumbar laminectomy surgery and axial mechanical back pain. The claimant was recommended for medial branch block.

The request for outpatient medial branch block right L5-S1 lumbar spine was denied by utilization review on 06/04/12 as the clinical findings on examination were not strongly consistent with facet joint mediated pain. The claimant continued to have signs of radiculopathy. The claimant saw Dr. on 06/11/12 with complaints of low back pain rating 6 out of 10 with associated soreness and stiffness. The claimant reported occasional right lower extremity symptoms. The note states the claimant was complaining primarily of axial mechanical back pain. Physical exam revealed tenderness to palpation of the mid to lower lumbar region. Kemp's was positive. There was pain in the right lower lumbar region with coughing. Straight leg raise caused back pain only. The right Achilles reflex was absent. The claimant was assessed with persistent pain status post lumbar laminectomy and microdiscectomy and right facet pain syndrome at L5 and S1. The claimant was recommended for right L5-S1 medial branch blocks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical documentation provided for review and current evidence based guideline recommendations for the request, medical necessity is not established. The claimant has been followed for ongoing chronic low back pain and radiculopathy. The claimant's most recent exam findings reveal tenderness to palpation in the mid to low lumbar region. There was no direct tenderness to palpation over the facets or documented pain with facet loading. It is unclear from the clinical documentation if the requested medial branch blocks are to determine the appropriateness of lumbar rhizotomy or as a therapeutic procedure. There is no indication from the clinical documentation that the requested medial branch blocks will be used in combination with evidence based therapy program as indicated in guidelines. As the clinical documentation provided does not meet guideline recommendations for the requested service, medical necessity is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL

BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)